



# Newport Fertility Center

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[www.NewportFertility.com](http://www.NewportFertility.com)

**Welcome! Please bring the following forms to your visit**

- 1. ASRM Patient History Form**
- 2. Patient Policy Form**
- 3. HIPPA and CF Forms**

## **Form N310, Patient Policy**

### **1. AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR BILLING**

*I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION REGARDING SERVICES BY THE PHYSICIAN/FACILITY TO PROCESS INSURANCE CLAIMS AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO FILE INSURANCE CLAIMS.*

### **2. ASSIGNMENT OF INSURANCE BENEFIT**

*I HEREBY AUTHORIZE IRREVOCABLY ASSIGNMENT OF PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE PHYSICIAN Dr. Kan or Newport Fertility Center AND FACILITY TO BE MADE DIRECTLY TO THE PHYSICIAN AND FACILITY.*

**3. FINANCIAL RESPONSIBILITY FOR NON-MEDICARE INSURANCE PATIENTS, REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND THAT I ALONE AM FULLY FINANCIALLY RESPONSIBLE FOR THE FEES FOR THE SERVICE RENDERED. I AGREE TO COLLECTION CHARGES FOR CHECKS NOT HONORED BY MY BANK. I ALSO AGREE TO SERVICE CHARGES WHICH WILL BE ADDED TO MY PAST DUE ACCOUNTS. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO VERIFY WITH MY INSURANCE COMPANY ABOUT THE TERMS OF INSURANCE BENEFITS FOR THE SERVICES RENDERED AT THIS OR ANY OTHER FACILITY FOR MY CARE.**

### **4. AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION FOR TREATMENT**

*I HEREBY AUTHORIZE THE ABOVE PHYSICIAN AND FACILITY TO OBTAIN AND RELEASE COPIES OF MY RECORDS AND INFORMATION REGARDING MY MEDICAL HISTORY, MENTAL, OR PHYSICAL CONDITION FOR THE PURPOSE OF FURTHER TREATMENT AND EVALUATION.*

### **5. CONSENT TO RECEIVE MESSAGES**

*MY SIGNATURE BELOW AUTHORIZES THE DOCTOR AND/OR FACILITY AND/OR STAFF TO IDENTIFY THEMSELVES FROM THE DOCTOR'S OFFICE AND/OR FACILITY WHEN CALLING TO LEAVE A MESSAGE REGARDING MY APPOINTMENT, RESULTS, OR OTHER MEDICAL INFORMATION ON ANY ANSWERING DEVICE OR WITH ANOTHER PERSON ANSWERING THE PHONE. THIS AUTHORIZATION WILL BE IN EFFECT AS LONG AS I REMAIN A PATIENT OF THIS PRACTICE.*

### **6. DISCLOSURE OF FINANCIAL INTEREST**

*I UNDERSTAND THAT DR. KAN HAS A PRINCIPAL FINANCIAL INTEREST IN HIS MEDICAL OFFICE AND A PRINCIPAL INTEREST IN THE FACILITY SERVICE AT A SEPARATE FACILITY BY THE NAME OF Newport Health Laboratories, INC., and Newport Beach Surgery Center.*

**7. HEALTH CARE ELIGIBILITY WAIVER** THE PATIENT OR PATIENT'S LEGAL REPRESENTATIVE HEREBY CERTIFIES THAT HE/SHE IS ELIGIBLE FOR HEALTH PLAN BENEFITS COVERAGE, AND HAS CHOSEN THE STATED PHYSICIAN AS THE PROVIDER OF HIS/HER CARE. FURTHERMORE, THE PATIENT'S LEGAL REPRESENTATIVE

N310

UNDERSTANDS THAT IF HE/SHE IS FOUND INELIGIBLE FOR COVERAGE OF PLAN BENEFITS, HE/SHE IS FINANCIALLY RESPONSIBLE FOR ALL COST INCURRED DURING THE DELIVERY OF HEALTH SERVICES, AND AGREES TO PAY THESE CHARGES TO THE PHYSICIAN ACCORDINGLY.

**Signature Page for Forms Newport Fertility Center**

Initials

HIPPA Form H101- I have read and understand the HIPPA policy

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Patient Policies N310- I have read and understand patient policies listed below:

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1. AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR BILLING
2. ASSIGNMENT OF INSURANCE BENEFIT
3. FINANCIAL RESPONSIBILITY FOR NON-MEDICARE INSURANCE PATIENTS
4. AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION FOR TREATMENT
5. CONSENT TO RECEIVE MESSAGES
6. DISCLOSURE OF FINANCIAL INTEREST
7. HEALTH CARE ELIGIBILITY WAIVER

**Cystic Fibrosis Form (CF122)-** I have read and understand the Cystic Fibrosis Information and:

- Decline testing for now, but will inform you if I would like to proceed
- Decline testing because I have been tested and informed by my doctor that I am negative
- Accept testing and would like an order for testing

Initials

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Signature

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Date

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Signature

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Date

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Print Name

\_\_\_\_\_  
Print Name

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Witness

\_\_\_\_\_  
Date

Print Name \_\_\_\_\_